GROUP DENTAL PLAN

CIGNA Preferred Provider (PPO)
CIGNA Dental Health (HMO)

INTRODUCTION

Universities Research Association, Inc./Fermi National Accelerator Laboratory has arranged with Connecticut General, a CIGNA company, to include a dual option dental plan in its benefit program. The two dental plans are the CIGNA Preferred Provider Plan (PPO) and the CIGNA Dental Health Plan (CDH).

The Preferred Provider Plan allows you to go to any licensed dentist or specialist of your choice. However, when you go to a dentist or specialist in the preferred provider network, you will save yourself some money. Your co-insurance cost will be less because of the discount arrangement between Connecticut General and the participating providers in the network.

The Preferred Provider Plan has a deductible and annual maximum of benefits. In the PPO Plan preventive and diagnostic care is paid at 100% of the contracted fee for participating provider care, restorative care is paid at 80% of the contracted fee for participating provider care and major restorative care is paid at 50% of the contracted fee for participating provider care.

When you receive services from a non-participating provider, preventive and diagnostic care is paid at 100% of reasonable and customary charges, restorative care is paid at 80% of reasonable and customary charges and major restorative care is paid at 50% of reasonable and customary charges.

The CIGNA Dental Health Plan is a health maintenance organization (HMO). You must select a primary care dentist under contract with the HMO. Referrals to specialists are arranged through the primary care dentist. There are no claim forms and no costs to you for diagnostic, preventive and many basic dental services and reduced fees for complex dental services.

WHO IS ELIGIBLE

All employees and their dependents except dayworkers and summer employees are eligible to enroll for dental coverage as of the first day of employment.

If both husband and wife are employees of Fermilab, one may elect to be covered as a dependent of the other for dental coverage; or both can elect to be covered as employees. Dependent children whose parents are both employees of Fermilab may be covered under one plan only.

Who is an eligible dependent

- Your lawful spouse.
- Your unmarried child who is less than 19 years old.
- Your unmarried child who is less than 23 years old, a full-time student and primarily supported by you.
- Your unmarried child who is mentally or physically incapable of earning a living may be continued beyond age 19, if 60 days before they reach the age limit, you submit proof of the child's incapacity to the Preferred Provider plan or the CIGNA Dental Health plan. Proof of the child's dependency may be required once a year.

Definition Of Dependent Child

Dependent child includes a child born of the employee, a child legally adopted by the employee, and stepchild of the employee living with the employee in a normal parent-child relationship.

If a qualified medical child support order is issued for your child, that child will be eligible for coverage as required by the order, and you will not be considered a late enrollee for dependent coverage. A qualified medical child support order is a judgement, decree or order issued by a court of competent jurisdiction and satisfies all of the rules to make it a qualified order. For details, see your group dental insurance certificate.

ENROLLMENT

At the employee orientation meeting on your first day of employment you can elect to enroll yourself and your family in one of the dental plans.

If you fail to enroll yourself or your family in the PPO plan within 30 days from your first day of employment or within 30 days from acquiring a dependent, the coverage will not be effective until Connecticut General/ CIGNA agrees in writing to insure you or your family.

If you fail to enroll yourself or your family in the CDH plan within 30 days from your first day of employment or within 30 days from acquiring a dependent, you will have to wait until the "open enrollment" period to enroll in the CDH plan.

Effective Date of Coverage

Your coverage and your family's coverage will be effective on the day you enroll, but no earlier than the day you and your family become eligible.

Late Enrollment

No dental examination will be required if you elect coverage for yourself and your family within 30 days from your first day of work or within 30 days from acquiring a dependent. If you elect coverage after that time you will be required to submit evidence of insurability before coverage is effective under the PPO plan. The CDH plan does not accept late enrollments. Coverage under the PPO plan will be limited as described in the Missing Teeth and Late Entrance section of this booklet.

Open Enrollment

Fermilab has an annual open enrollment in order for active employees to transfer dental coverage between the PPO dental plan and CDH dental plan. The annual open enrollment is held provided there is an approved alternate plan available.

Changing Plans

If you elect to transfer your coverage during an Open Enrollment Period, you will become insured under the new plan that you elect on the first day of the month after the end of the Open Enrollment Period. **However, if you or your dependent has started a program of orthodontic treatment under either plan, you may not elect to transfer from one option to the other until the Open Enrollment Period that follows six months after completion of the orthodontic treatment. In addition, any dental treatment started and not completed under one plan will not be covered under the other plan.**

If you are insured under the CDH plan, you may transfer to the PPO plan at any time should: (a) your designated dental facility terminate its contract with CDH, and no other CDH dental facility is available in the service area; or (b) you relocate outside the CDH service area. Your new coverage will be effective on the date the dental facility terminates, or the date of your move outside the service area, provided that as of that date you sign a new enrollment form for the PPO plan.

Cost

Fermilab pays for the major portion of the cost of dental coverage. Your monthly cost for single coverage under the PPO plan is $7.49 and under the CDH plan $7.63. Your monthly cost for family coverage under the PPO plan is $38.62 and under the CDH plan, $21.72.

(These are the rates effective on 10/1/02 and are subject to change.)

OUTLINE OF THE PREFERRED PROVIDER PLAN

In order for dental procedures to be covered under the PPO plan, the patient must be enrolled in this plan. The patient can receive services from any dentists or specialists of choice. However, if you use a preferred provider, your cost will be less. A list of preferred providers is available at **www.cigna.com/dental** or from the Fermilab Benefits Office.

There are four classes of services. The maximum that the plan pays for Class I, II, & III procedures is $1,500 per person per calendar year. Following is a sample of some services provided under each class. You should consult your ***Group Dental Insurance Plan*** certificate for a detailed list.

Class I - Diagnostic & Preventive Procedures

a. No deductible.

b. Plan pays 100% of reasonable and customary charges for non-participating provider care or 100% of the contracted fee for participating provider care:

- Oral exams - two per person per year
- Cleaning - two per person per year
- Bitewing x-rays - two per person per year
- Complete series of x-rays - one per person in any 3 calendar years
- Emergency treatment to relieve pain when no other definitive dental service is performed
- Fluoride treatment - one per person per year (limited to persons under age 19)
- Space maintainers (limited to non-orthodontic treatment)

Class II - Basic Restorative Procedures

a. $50.00 deductible per person per calendar year (limited to 3 per family)

b. Plan pays 80% of reasonable and customary charges for non-participating provider care or 80% of the contracted fee for participating provider care:

- Amalgam filling
- Root canal therapy
- Simple extraction
- Surgical extractions
- Periodontal scaling and root planing

Class III - Major Restorative Procedures

a. Common deductible with Class II procedures

b. Plan pays 50% of reasonable and customary charges for non-participating provider care or 50% of the contracted fee for participating provider care:

- Crowns
- Dentures
- Bridges

Class IV- Orthodontic Procedures

a. Limited to dependent children under age 19

b. No deductible

c. Plan pays 50% of reasonable & customary charges for non-participating provider care or 50% of the contracted fee for participating provider care:

d. Lifetime maximum of $1,500

OUTLINE OF THE CIGNA DENTAL HEALTH PLAN

In order for dental procedures to be covered under the CDH plan, the patient must be enrolled in this plan and receive services from the primary dentist under contract with CDH. Dental services provided by specialists will be covered when the patient has been referred by the primary care dentist to specialists under contract with CDH. A list of CDH providers is available at **www.cigna.com/dental** or Fermilab's Benefits Office.

Following are some covered procedures, and the amount that the patient would pay under patient charge schedule F1-03 (4/00). Consult your ***Group Dental Insurance Plan*** certificate or Fermilab's Benefits Office for a detailed list. (The patient charge schedule is subject to annual review and change.)

Diagnostic/Preventive Procedures	***Patient Cost***
Oral exams, once each 6 months	No Charge
X-rays	No Charge
Cleaning, once each 6 months	No Charge
Fluoride treatment, once each 6 mos, dependent child up to age 19	No Charge
Space maintainer - fixed	No Charge
Restorative Procedures	***Patient Cost***
Amalgam fillings 1, 2, 3 or 4 surfaces	No Charge
Anterior or bicuspid root canal	No Charge
Molar-root canal (one)	$200.00
Simple extraction & soft tissue impaction	No Charge
Partial bony impaction	$45.00
Complete bony impaction	$80.00
Major Restorative Procedures	*Patient Cost*
Crown and Bridge	
Porcelain or ceramic crown per unit	$335.00
Porcelain fused to metal crown per unit	$325.00*
Pontic, porcelain fused to metal per unit	$325.00*
Dentures	
Partial upper or lower w/clasps	$340.00
Complete upper or lower denture (standard)	$300.00

*There will be an additional charge for multiple crown units—ask your dentist for guidelines.

Orthodontics	***Patient Cost***
Evaluation	$ 40.00
Treatment plan & records	$150.00
Therapy for a normal 24 mo. fully banded case:	
Children to age 19	$1,600.00
Adults	$2,200.00

Services Not Covered - PPO Plan & CDH Plan

Check your Group Dental Insurance Plan certificate for a detailed list of exclusions and limitations that are unique to the particular plan.

No payment will be made for expenses incurred by you or your dependents for:

- treatment started and not completed under one plan will not be covered under the other plan;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a hospital;
- services performed solely for cosmetic reasons;
- any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards;
- services in connection with an injury arising out of, or in the course of, any employment wage or profit;
- replacement of a lost or stolen appliance;
- procedures, appliances or restoration whose main purpose is to a) change vertical dimension, or b) diagnose or treat conditions or dysfunction of the temporomandibular joint except as specified in the patient charge schedule of the CDH plan;
- prescription drugs and the administration of sedation or a general anesthesia;
- services in connection with a sickness which is covered under workers' compensation or similar law;
- services in a hospital owned or run by the United States Government, unless the person is legally required to pay for such charges;
- services which the person is not legally required to pay;
- charges which exceed the reasonable and customary charges;
- services that you or your dependent are entitled to payment through a public program other than medicaid;
- services which are experimental procedure or treatment methods not approved by the American Dental Association or the appropriate speciality society; and
- expenses to the extent that benefits are payable under the mandatory part of any auto insurance policy written to comply with no-fault insurance law or uninsured motorist insurance law.

Missing Teeth And Late Entrant Limit

This limit applies to the PPO Plan only. Payment for the following covered dental services will be 50% of the amount otherwise payable for:

- Class III or Class IV dental services when an individual enrolls in the plan after 30 days of employment; or
- first replacement of teeth that are missing when an individual became insured for these benefits.

After an individual has been continuously insured for these benefits for 24 months, this limit will no longer apply. If an individual transfers from the CDH plan directly to the PPO plan, credit will be given for the length of time the individual was insured under CDH.

Pretreatment Review

The pretreatment review under the PPO plan is designed to give you and your dentist a better understanding of the covered expenses payable under this plan before services are provided. When charges for a proposed dental procedure or series of dental procedures are expected to exceed $200.00, your dentist should submit a claim form to the PPO plan showing the treatment plan and fees. The PPO plan will then use this pretreatment review to determine the benefits which will be payable for each dental service according to the terms of the plan and notify your dentist accordingly. You can find out the results of the review from your dentist. When the treatment plan is finished, your dentist should resubmit the claim form for payment showing the date each service was performed.

The pretreatment review is not required, but it is a good idea to know beforehand what you may be responsible to pay.

COORDINATION OF BENEFITS (COB)

When you or any one of your dependents are covered under more than one group dental plan, benefits from the PPO plan will be coordinated with the benefits from any of your other group dental plans so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid by the plans. The rules below establish the order in which benefits will be determined.

- The plan with no COB provision is always primary.
- The plan that covers the individual as an employee is primary. The plan that covers the individual as a dependent is secondary.
- The plan that covers the individual as an active employee is primary. The plan that covers the individual as a retired employee is secondary.
- The plan of the parent whose birthday falls earlier in the year is primary.
- If parents are separated or divorced, the primary plan is that of the parent who has custody. If there is a court decree designating one parent as responsible for health care expenses, that parent's plan will be primary.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates:

- The date you are no longer a member of an eligible class of employees.
- The date the group policy cancels.
- The date your employment terminates.
- The date you fail to make the required contributions.
- A family member's coverage terminates when the member is no longer eligible.

Extension of Benefits Following Termination of Insurance

Certain dental procedures that are in progress at the time dental benefits are terminated can be considered covered expenses if they are completed within three months from termination of insurance. (See your Group Dental Insurance Plan certificate for details.)

Rights at Termination of Insurance (COBRA)

Federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA), enables you or your covered dependents to continue dental coverage under certain circumstances when coverage would otherwise terminate. To continue dental coverage, you or your covered dependents must pay the full cost plus a 2% administrative fee.

You or your covered dependents may elect to continue dental coverage for 18 months if your coverage terminates because your employment terminates for any reason except gross misconduct. Coverage can be extended to 29 months if Social Security Administration determines that you or a covered dependent are disabled or become disabled within 60 days from the date of termination of employment.

The coverage extension is available to the disabled individual and the individuals nondisabled family members who are entitled to COBRA continuation. Premiums during the additional 11 months of coverage will be at a substantially higher rate than for the initial 18 month period (150% of the current rate.)

To qualify for the extension, you must notify Fermilab's Benefits Office in writing. In addition, you must submit a copy of the Social Security disability determination within 60 days of the date of the notice to Fermilab's's Benefits Office.

Dental coverage may be continued by covered dependents for up to 36 months if their coverage terminates because of one of the following events:

- your divorce or legal separation, or
- your child ceases to qualify.

The election form to continue dental and medical coverage is given to you at your exit interview. Otherwise it is available from the Benefits Office, 15th floor Wilson Hall, extensions 4362 or 3395.

You must elect continuation of coverage within 60 days of loss of coverage. From the date of election you have an additional 45 days to pay the required retroactive premium to avoid a gap in coverage.

If your covered dependents elect continuation coverage due to your termination of employment, they will be entitled to additional months of coverage (up to 36 months) if, during the first 18 months:

- you die,
- you divorce or legally separate,
- your child ceases to qualify as a dependent, or
- you become eligible for Medicare.

In order to be eligible for continuation of coverage, it is your or your dependents responsibility to notify the Benefits Office within 60 days from the date of these events.

Additional information regarding COBRA rights and benefits are in your Group Dental Insurance Plan certificate.

Termination of COBRA Benefits

Continuation of COBRA coverage will stop before the end of the established time period if:

- you or your dependents become covered under any other group dental plan,
- you or your dependents become eligible for Medicare,
- the required premiums are not paid within 30 days of the due date, or
- the plan is terminated

Additional information regarding termination of COBRA benefits are in your Group Dental Insurance Plan certificate.

CONVERSION PRIVILEGE

At the end of your or your dependent's COBRA continuation period, you or your dependent may be eligible to convert to an individual dental conversion policy. You may arrange for a conversion policy during the 180 day period before your or your dependent's COBRA period ends. You must apply in writing to Connecticut General and pay the first premium within 31 days after the date your COBRA coverage terminates.

If you are ineligible for COBRA benefits, you may be able to convert to a conversion policy. You must apply in writing to Connecticut General and pay the first premium within 31 days after the date group dental coverage terminates. Additional information regarding the conversion privilege is in your Group Dental Insurance Plan certificate.

LEAVE OF ABSENCE

If you are granted a leave of absence, you may continue your and your dependent's group dental coverage as long as you pay the full cost. You must notify the Benefits Office to make arrangements to continue the group dental coverage before your leave starts. Your group dental coverage will terminate at the start of your leave if you fail to elect continuation of coverage within 60 days of the start of your leave. If you elect coverage and you fail to return from leave, COBRA premiums will then apply.

If your request for a leave of absence meets the criteria for leave under the Family Medical Leave Act (FMLA), you may continue your and your dependent's group dental coverage as long as you pay the current employee deduction for such coverage. (See Fermilab's Personnel Policy Guide for details regarding FMLA).

MILITARY LEAVE

If you are absent from work in order to fulfill a period of duty in the U.S. Uniformed Services, you and your dependents shall be treated as any other qualified beneficiary under COBRA continuation of benefits. (See section "Rights at Termination of Insurance - COBRA.) If your period of military leave is less than 31 days, you will be required to pay the employee share for coverage.

LAYOFF

Dental coverage ends on your last working day. If you are eligible for severance and if the run out payout option under the severance plan is an option available to you, your dental coverage will continue to the end of the payout period as long as you pay your portion of the premiums, and the plan is not terminated. COBRA continuation rules apply concurrently with severance runout period.

DISABLED EMPLOYEES

If you are disabled and receiving benefits under the long term disability plan, you and your eligible dependents will continue to be covered under the dental plan. You must pay your portion of the required premium. If you elect early retirement, dental coverage terminates and COBRA continuation rules apply.

HOW TO FILE A CLAIM

PPO Plan

Dental claim forms are available from the Benefits Office, 15th floor Wilson Hall. You and your dentist should complete the appropriate section of the form and mail it directly to:

CIGNA Healthcare Service Center
P.O. Box 15558
Wilmington, DE 19850-5558
1-800-441-7150

The dental claim should be filed as soon as you have incurred or completed the services. The prompt filing of a completed claim form will result in faster payment of your claim.

CIGNA Dental Health Plan

There are no claim forms to complete and submit. Itemized bills for emergency treatment should be submitted to your primary care dentist for processing.

GRIEVANCE PROCEDURES

PPO Plan

The procedure is described in the ERISA Information Section of this booklet. All complaints can also be directed to the Illinois Insurance Department, Consumer Services Section, 320 West Washington, Springfield, Illinois 61767.

CIGNA Dental Health Plan

If you have questions about your treatment plan or the care process, you can call or write to:

CDH Professional Relations Department
P.O. Box 18906
Plantation, FL 33318-9060
1-800-367-1037

In addition all complaints can be directed to the Illinois Insurance Department, Consumer Services Section, 320 West Washington, Springfield, Illinois 61767. ERISA rights apply as described in the ERISA Information Section of this booklet.

ERISA INFORMATION

Plan Name

Dental Insurance

Plan Number

506

Employer Identification Number

52-0816670

Plan Sponsor

Universities Research Association, Inc.
(Fermi National Accelerator Laboratory)

Type of Plan

Welfare

Plan Year Ends

The benefit plan records are kept on a calendar year basis. The plan year ends each December 31.

Plan Administrator

Head, Laboratory Services
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, Illinois 60510
(630) 840-3396

Plan Fiduciary

Vice President
Universities Research Association, Inc.
Suite 400
1111 19th Street N.W.
Washington, D. C. 20036

Agent For Services of Legal Process

Plan Administrator and/or Plan Fiduciary

Plan Cost

Paid by the employer and employee.

Effective Date

April 1, 1979.

Benefits Provided By

CIGNA
Connecticut General Life Insurance Company
195 Broadway 12th Floor
New York, NY 10007

Eligibility

All active employees and their eligible dependents except dayworkers and summer employees.

Loss of Benefits

You and your eligible dependents must continue to be a member of an eligible class and continue to make any required contributions. Universities Research Association, Inc. and Fermi National Accelerator Laboratory maintain

the right through the Plan Administrator to modify, amend or terminate the dental plan described in this booklet.

Collective Bargaining Agreements

Benefit information can be found in the following labor agreements.

- Local No. 113, International Association of Machinists (AFL-CIO): Machinist and Welders.
- Local No. I-21, International Association of Fire Fighters (AFL-CIO): Fire Fighters.
- Local No. 113, International Association of Machinists (AFL-CIO): Computer Operators.
- Local No. 113, International Association of Machinists (AFL-CIO): Electricians and Mechanics.

Requests For Information and Claim Procedures

Request for information and claims concerning eligibility, participation, contributions, or other aspects of the operation of any plan should be directed to the Plan Administrator.

If a written request or claim is denied, the Administrator shall, within a reasonable time, provide a written denial to the participant. It will include the specific reasons for denial, the provisions of the plan upon which the denial is based, a description of any material needed to complete the claim (if appropriate) and why it is necessary, and instructions on how to apply for a review of the claim. When the Administrator requires additional time to process a claim because of special circumstances, an extension may be obtained by notifying the participant that a decision on the claim will be delayed, what circumstances have caused the delay and when a decision can be expected. The Administrator will inform the participant of the delay within ninety days of the date the claim was submitted.

A participant may request in writing a review of a denied claim and may review pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the participant a decision upon such request for review of a denied claim within sixty days of receipt of the request. When special circumstances require an extension, the Administrator may obtain such extension by notifying the participant that the decision on the review of the denied claim will be delayed, why and when a decision can be expected. See each plan's section for specifics on how to file a claim.

Rights and Protections

The following statement of ERISA rights is required by federal law and regulation. As a participant in the retirement and welfare plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The Plan Administrator's Office is located at Robert R. Wilson Hall, 15th floor southeast.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator.

3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the

above rights. For instance, if you request materials from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Dept. of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.